

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for dates of service (DOS) 08/15/01 and 09/24/01?
b. The request was received on 04/15/02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC-60 and Letter Requesting Dispute Resolution
 - b. Provider marked exhibits
 - c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC-60 and Response to a Request for Dispute Resolution
 - b. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g)(3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 05/31/02. Per Rule 133.307 (g)(4), the carrier representative signed for the copy on 05/31/02. The response from the insurance carrier was received in the Division on 06/14/02. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Medical Dispute is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The provider has not received proper reimbursement for services associated with an epidural steroid injection.
2. Respondent: The carrier has reimbursed the provider properly.

IV. FINDINGS

1. Based on Commission Rule 133.307 (d)(1&2), the only dates of service eligible for review are 08/15/01 and 09/24/01.
2. The carrier's EOBs have the denials, "F-N – THE MEDICAL FEE GUIDELINE STATES IN THE IMPORTANCE OF PROPER CODING 'ACCURATE CODING OF SERVICES RENDERED IS ESSENTIAL FOR PROPER REIMBURSEMENT'. THE

SERVICES PREFORMED ARE NOT REIMBURSABLE AS BILLED”, “G – 04/01/96 TWCC MEDICAL FEE GUIDELINE GROUND RULES INDICATE THAT THIS SERVICE IS AN INTEGRAL COMPONENT OF ANOTHER SERVICE, PROCEDURE, OR PROGRAM. SEPARATE REIMBURSEMENT IS NOT ALLOWED FOR THIS PROCEDURE” and “U – THIS SERVICE HAS BEEN DEEMED UNNECESSARY MEDICAL TREATMENT BASED ON A REVIEW OF THE CLAIM FILE, BILLING RECORDS AND WRITTEN PROTOCOLS ESTABLISHED FOR APPROPRIATE HEALTH CARE TREATMENT”.

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	BILLED	PAID	EOB Denial Code	MARS	REFERENCE	RATIONALE:
08/15/01 09/24/01	76499-27-22	\$350.00 \$350.00	\$0.00 \$0.00	F-N U	DOP	MFG, GI (I)(A&B) & (III), CPT & modifier descriptors, TWCC Advisory 97-01; Texas Workers' Compensation Commission Act & Rules, Rules 134.600 (a)(5), 133.301 (a) & 133.304 (c)	<p>*Both the Requestor's and the Respondent's information indicates that preauthorization was obtained, even though not required. Per Rule 133.301 (a), "The insurance carrier shall not retrospectively review the medical necessity of a medical bill ...for which the health care provider has obtained preauthorization..." therefore, the carrier's use of the denial "U" does not appear to be proper and does not meet the requirements of Rule 133.304 (c). However, an improper denial code does not create carrier liability through waiver.</p> <p>The CPT descriptor states, "Unlisted diagnostic radiologic procedure." The medical documentation indicates that the provider is billing for fluoroscopic guidance (fluoroscopy). The MFG GI (I)(A) states, "... (TWCC) has incorporated usage of the ... (AMA's) 1995 ... (CPT) codes". The MFG has CPT code 76000 which has the descriptor "Fluoroscopy (separate procedure), up to one hour physician time, other than 71023 or 71034 (eg. cardiac fluoroscopy)". The CPT code 76000 is sufficiently descriptive of the procedure performed and the MAR value of 76000-27 is \$88.00. Therefore, the provider is entitled to reimbursement of \$176.00 (\$88.00 X 2 DOS).</p>
08/15/01 09/24/01	76499-27	\$300.00 \$300.00	\$0.00 \$0.00	F-N U	DOP	MFG, GI (II)(A&B) & (III), CPT & modifier descriptors, TWCC Advisory 97-01; Texas Workers' Compensation Commission Act & Rules, Rules 134.600 (a)(5), 133.301 (a) & 133.304 (c)	<p>See *paragraph above.</p> <p>The TWCC Advisory 97-01 states, "...When videofluoroscopy or fluoroscopy is performed with a myelogram or discogram, such procedures (emphasis added) are considered part of the service and should not be billed separately. The procedure in dispute is an epiduragram and is a procedure that should not be reimbursed separately. Therefore, no reimbursement is recommended.</p>
08/15/01 09/24/01	A4649 A4209 A4550	\$15.00 \$10.00 \$145.00	\$0.00 \$0.00 \$0.00	G G G	DOP DOP DOP	MFG, SGR (V)(B)(1)	<p>The referenced SGR discusses the billable CPT codes for surgical procedures performed in a doctor's office. They are CPT codes 99070-ST, 99070-AS & 99499-RR. The CPT codes in dispute are not one of these billable codes. Therefore, reimbursement is not recommended.</p>
Totals		\$1470.00	\$0.00				The Requestor is entitled to reimbursement of \$176.00.

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$176.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 17th day of September 2002.

Larry Beckham
Medical Dispute Resolution Officer
Medical Review Division